STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIMINDRIC	01	COMPLETED
		155364	A. BUILDING		09/07/2011
		<u> </u>	B. WING	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIE	R	ı	LIMA ROAD	
BYRON I	HEALTH CENTER		l l	WAYNE, IN46818	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
K0000					
•		_	170000	This Dian of Correction will	
	A Life Safety C	ode Recertification	K0000	This Plan of Correction will as the written allegation of	serve
	and State Lice	nsure Survey was		compliance. Preparation a	nd / or
	conducted by	the Indiana State		execution of the plan of cor	
	Department of	^f Health in		does not constitute admissi	l l
	· ·	th 42 CFR 483.70(a).		agreement by Byron Health	
				Center of the truth of the fa	ı
	Survey Date: (00/06/11 and		alleged or conclusions set f	l l
	1	J3/OU/II allu		the statement of deficiencie The Plan of Correction is	es.
	09/07/11			prepared as a provision of f	ederal
				and state regulations.	Cuciai
	Facility Number	er: 000255]	
	Provider Number: 155364				
	AIM Number:	100273280			
	Surveyor: Am	y Kelley, Life Safety			
	Code Specialis				
	Code Specians				
	At this Life Saf	Coty Codo cumou			
		ety Code survey,			
	· -	Center was found not			
	•	with Requirements			
	for Participation	on in			
	Medicare/Med	icaid, 42 CFR			
	Subpart 483.7	0(a), Life Safety			
	from Fire and	the 2000 edition of			
	the National Fi	re Protection			
		FPA) 101, Life Safety			
	•	napter 19, Existing			
		· ·			
		ccupancies and 410			
	IAC 16.2.				
	This four story	facility with a			
	basement was	determined to be of			
	I		1	1	I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C7DX21

Facility ID:

000255

TITLE

If continuation sheet

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMP 09/07/2	LETED	
	PROVIDER OR SUPPLIER		12101 L	ADDRESS, CITY, STATE, ZIP COD LIMA ROAD WAYNE, IN46818	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	fully sprinklere a fire alarm sys detection in co open to the co has a capacity census of 123 survey. Quality Review by Code Specialist-Me The facility was compliance wit aforementione	h the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364		IDENTIFICATION NUMBER:	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01 DDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 09/07/2	ETED
	ROVIDER OR SUPPLIER			12101 L	IMA ROAD /AYNE, IN46818		
(X4) ID PREFIX TAG K0018	(EACH DEFICIEN REGULATORY OR Doors protecting of	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) corridor openings in other		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
SS=E	exits, or hazardou doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with keeping the door of meeting 19.3.6.3.6. Roller latches are regulations in all he Based on observitions in all he second floor we 21 corridor door of 10 corridor north were equal taching hardward practice could near the second and any resident through the Second 3 north of an emergence of an emergence of 109/06/11 at 25	prohibited by CMS lealth care facilities. Evation and facility failed to corridor doors to the leight room, 19 of lors in Section 1 and or doors in Section 3 lipped with positive lare. This deficient laffect any resident defloor weight room int evacuated ction 1 hall or or halls in the event lety. I observation with Plant Operations on	K0	018	A. DOOR LATCH ON 2ND FLOOR WEIGHT ROOM DO (OCCUPIED RESIDENT AREA)1. Door Latch on the 2 Floor Weight Room Door will replaced with a latch that latch into the door frame.2. In the of a fire, any resident in the vicinity of the weight room contained have been affected by this practice. All other door latch resident occupied areas were inspected and found to adhe code.3. Door latches will be inspected by maintenance stas part of routine facility inspections. Door latches for to be defective will be replaced.4. Facility issues with reported to the facility wide of committee on a quarterly basis.5. Date of Completion 10/7/2011.B. CORRIDOR ROOMS OF UNOCCUPIED SECTIONS 1 & 3Sections 1 are currently vacant units and unlicensed with the state. The	2nd be ches case buld es in e re to raff und II be QA is	10/14/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155364		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/07/2011	
	PROVIDER OR SUPPLIER		12101 L	ADDRESS, CITY, STATE, ZIP CODE LIMA ROAD VAYNE, IN46818	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hardware. This by the Director at the time of control b. Based on obtaining the Director of Plan 09/06/11 at 2: corridor doors had roller latch on 09/07/11 at corridor doors north had rolle instead of positive required. Emeridentified each emergency egrous Based on an interpretation of observations.	eservations with the at Operations on 40 p.m., nineteen in the Section 1 hall ing hardware and to 10:45 a.m., nine in the Section 3 restricted hardware tive latching hardware tive latching as regency exit signs of these halls as ess corridors. The serview with the at Operations at the attions, the Section on 3 north hall are dand used for		units are not used in any typ resident care. These units a closed and locked and not o to any passing traffic. One E sign will be removed from Cl Section 1 and two Exit signs be removed from Closed Se 3. "Not an Exit" signs will be fastened to the old exit Sectiduble doors. "Not an Exit" will be fastened to old exit Signs and the section 1 and the section 1 and two Exit Signs will be fastened to the old exit Signs will be fastened to old exit Signs and the section 1 and the s	are pen exit losed will ction e ion 1 signs ection areas stair, on 12 ee to estair, nce ens as eging y e
K0038 SS=E	readily accessible with section 7.1. Based on obser and previous mand facility failed to corridors were	vation, interview leasurements; the lensure 2 of 18	K0038	While cited as deficient, n residents have been affected this deficient practice. Residents are no required to use the corriders as deficient. No resident livi	t cited

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION 01	COMPL		
ANDILAN	OF CORRECTION	155364		ILDING	01	09/07/2	
		130001	B. WIN		DDDEGG GITTL GTATE GTA CORE] 33/3//2	V
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BYRON I	HEALTH CENTER			1	.IMA ROAD VAYNE, IN46818		
		TATEL OF DEFICIENCIES		<u> </u>	W (1142, 11410010		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	7.1.5 requires	the means of egress			areas, activities, or services	are	
	=	ed and maintained			conducted in areas requiring	9	
	_	quate headroom as			residents to access ths corider.3. Waiver has been		
	•	er sections of this			issued by the state for many	,	
	=	not be less than 7			years and will be continued.	(See	
		ejections from the			State Form 54147 - Life Saf	-	
	-	than 6 ft. 8 inches			Code Waiver Request).4. N monitoring required, but res		
	_	above the finished			incidents are reported to fac		
	_	imum ceiling height			wide QA Committee on a		
		ined for not less			quarterly basis.5. No system		
		of the ceiling area			changes were made and no completion date is needed.	'	
		space, provided			'		
	=	ht of remaining					
		not less than 6 ft. 8					
	_	nt practice could					
	affect any resic	•					
	visitors in the f	acility who would					
	use these base	ment corridors.					
	Findings includ	e:					
	Based on obser	vations on					
	09/06/11 from	11:45 a.m. to 3:15					
	p.m. and on 09)/07/11 from 9:45					
	a.m. to 1:15 p.	m. with the Director					
	=	ions, the following					
		sement failed to					
	provide adequa	ite headroom:					
		nt ceiling height in					
		corridor measured					
	six feet two an	d one half inches.					
	Additionally, th						
	protruding belo	ow the ceiling along					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		12101 L	ADDRESS, CITY, STATE, ZIP CO LIMA ROAD VAYNE, IN46818	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	five feet seven floor. Based or Director of Plantime of observations are accurated. The ceiling basement corriwall measured inches. Additionally which ran along basement corrisist feet from the north-south control or that mine inches from an interview of Plant Operation.	from the previous 01/10 were used te. height at the south dor smoke barrier five feet nine onally, there was a g below the ceiling g the center dor that measured he floor and the orridor intersection ruding below the an along the heasure five feet m the floor. Based of with the Director sions at the time of the measurements ous survey on				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		ONSTRUCTION 01	(X3) DATE COMPL	
	155364	1			09/07/2	011
			12101 L	LIMA ROAD		
SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROUDERS N. AN OF CORRECTION		(X5)
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
installed in accorda Standard for the In Systems, to provid portions of the buil properly maintaine 25, Standard for the Maintenance of W. Systems. It is fully reliable, adequate system. Required equipped with wate switches, which are the building fire also 1. Based on obtinterview, the facensure 2 of 2 sthe small conferent and 2 of 11 sporthird floors nur were separated as required by Section 5–6.3.4 be located no conferent exident near the nurses' station small conference event of an emotion of the Director of standard and the Director of standard for the standard and the Director of the systems.	ance with NFPA 13, astallation of Sprinkler le complete coverage for all lding. The system is ad in accordance with NFPA are Inspection, Testing, and ater-Based Fire Protection of supervised. There is a water supply for the sprinkler systems are er flow and tamper the electrically connected to arm system. 19.3.5 asservation and accility failed to prinkler heads in the arence room closet rinkler heads in the asses' station area by at least six feet NFPA 13. NFPA 13, arequires sprinklers closer than six feet enter. This are could affect any the third floor and any staff in the are room in the aregency. e: observation with Plant Operations on	K	0056	designed with a wood panel the center of the closet which divided the closet into two ur A sprinkler head was installe both sides of the closet. The wood panel was removed in years creating one open close. One of the sprinkler heads we removed so that the area will meet code. Any resident of in the small conference room could have been affected by deficient practice; however, incidents have occurred. Sprinkler heads be checked during routine maintenance rounds and any defects will be corrected. Facility Issues we reported to the facility wide Committee on a quarterly base Date of Completion is 10/7/2011. B. Third floor nurse Station 1. One sprinkler heads be moved so as to be	down in this. d in this this this this this this this this	11/07/2011
	PROVIDER OR SUPPLIER SUMMARY'S (EACH DEFICIENT REGULATORY OR If there is an autor installed in accord Standard for the Ir Systems, to provic portions of the buil properly maintaine 25, Standard for tr Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which ar the building fire ala 1. Based on ob- interview, the fr ensure 2 of 2 s the small confer and 2 of 11 spr third floors nur were separated as required by Section 5–6.3.4 be located no or deficient practi resident near tr nurses' station small conference event of an emi- Findings includ a. Based on an the Director of	DENTIFICATION NUMBER: 155364 PROVIDER OR SUPPLIER HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to	PROVIDER OR SUPPLIER HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the small conference room closet and 2 of 11 sprinkler heads in the third floors nurses' station area were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5–6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident near the third floor nurses' station and any staff in the small conference room in the event of an emergency. Findings include: a. Based on an observation with the Director of Plant Operations on	PROVIDER OR SUPPLIER HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the third floors nurses' station area were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident near the third floor nurses' station and any staff in the small conference room in the event of an emergency. Findings include: a. Based on an observation with the Director of Plant Operations on	DENTIFICATION NUMBER: 155364 A BUILDING S WING	OF CORRECTION IDENTIFICATION NUMBER: 1553644 1553644 1553644 1553644 1553644 1553644 1553644

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7DX21 Facility ID:

000255

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	l ,	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A RICHEDING 01 COMPLETED					
		155364	A. BUI B. WIN	ILDING NG		09/07/2	011
NAME OF I	PROVIDER OR SUPPLIE	<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
		C .		1	LIMA ROAD		
BYRON	HEALTH CENTER			FORT \	WAYNE, IN46818		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		om closet had two	1	1110	closer than six feet on		Ditte
					center.2. Any resident, staff		
	sprinkler heads located less than six feet apart.				visitor near the third floor nul station could have been affe		
	I	n observation with			by this deficit practice; howe		
		Plant Operations on			no incidents have		
		2:32 p.m., the third			occurred.3. Sprinkler heads	will	
		tation area had two			be checked during routine maintenance rounds and any	٧	
		s located less than			defects will be		
	six feet apart r	near the # 2			corrected.4. Facility Issues w		
	elevator.				reported to the facility wide (committee on a quarterly	AK	
	This was acknowledged by the Director of Plant Operations at the time of observations.				basis.5. Date of Completion	is	
					10/7/2011.C. Kitchen Loadir	•	
					Dock1. The kitchen loading of will have one extended cove		
					dry side-wall sprinkler head	.ago	
	3.1-19(b)				installed by our sprinkler system		
					vendor.2. Any kitchen staff ir loading dock vicinity during a		
	2. Based on ol				could have been affected by		
		facility failed to			deficient practice; however, i		
	ensure comple				incidents have occurred.3. C the sprinkler head as been	nce	
	l ·	m was provided for			installed, deficit situation will	be	
		loading dock areas			rectified.4. The sprinkler hea	ad	
	in accordance	with NFPA 13, ne Installation of			will be monitored along with		
	Sprinkler Syste				entire fire suppression systemathrough quarterly inspections		
	1 -	rage for all portions			the vendor.5. Date of	-	
		. This deficient			Completion. Sprinkler head		
	1	ot in a resident care			be installed and operational to 11-05-11.	prior	
	l -	affect any number					
	of kitchen staf	-					
	Findings includ	de:					
	Based on an ol	oservation with the					
	<u> </u>						

000255

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	A. BUILI	DING	STRUCTION 01	(X3) DATE S COMPLI 09/07/20	ETED
NAME OF B	PROVIDER OR SUPPLIER		B. WING		DDRESS, CITY, STATE, ZIP CODE	09/07/20	J11
	HEALTH CENTER				MA ROAD AYNE, IN46818		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
IAU	Director of Plan 09/07/11 at 10 enclosed loadin of the kitchen v separated from garage door lad	at Operations on 0:20 a.m., the ag dock in the back which was the outside with a cked sprinkler ad on an interview or of Plant the time of a confirmed the id not have a		TAG			DATE
K0062 SS=E	continuously main condition and are periodically. 19. 25, 9.7.5 Based on obser interview, the f	acility failed to sprinkler heads in or shower room ed (dirty). LSC all automatic ms shall be maintained in h NFPA 25,	K00	062	1. The sprinkler head ne the 2nd floor shower room the had a build up of grime on it I been replaced. 2. Any stresidents, or visitors near the floor shower room during a ficuld have been affected; however, no incidents have occurred.3. All sprinkler heads in occcupied resident areas will be set up on a clear schedule within the Housekeeping Department to	at nas aff, 2nd re	10/07/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7DX21 Facility ID:

000255

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155364	A. BUILDING	01	09/07/2011
		100007	B. WING		00/01/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BYRON I	HEALTH CENTER		I	LIMA ROAD WAYNE, IN46818	
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	N BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE DATE
	Testing, and M	aintenance of		eliminate this deficient pra	octice
	Water-Based Fi			from happening in the	
	Systems. NFPA	25, 1998 edition,		future.4. Director of Environmental Services w	rill report
	2-2.1.1 require			to the facility wide QA Cor	
	-	ed which is painted,		of the schedule and progr	ess of
	=	aged, loaded, or in		the cleaning schedule quarterly.5. Date of	
	•	rientation. This		Completion 10/7/11	
		ce could affect all			
	=	near the second			
	floor shower ro	oom.			
	Findings includ	e:			
	Based on obser	vation with the			
	Director of Plar	nt Operations on			
		15 p.m., there was			
	a buildup of gr	ime on the			
	=	near the door in			
		or shower room.			
		terview with the			
		nt Operations at the			
		ation, when asked			
		e sprinkler head he			
	stated grime th				
		scraped off with			
	his fingernail.				
	3.1-19(b)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155364			LDING	01	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		•	12101 L	ADDRESS, CITY, STATE, ZIP CODE LIMA ROAD WAYNE, IN46818		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
K0070 SS=D	in all health care of non-sleeping staff the heating eleme exceed 212 degre 19.7.8 Based on obser interview, the fa policy for the portable space facility in accordict 101, Section 19 deficient praction resident care at any staff in the office. Findings includes Based on obser Director of Plar 09/06/11 at 2: a space heater Life office. Bas with the Director of the Operations at the staff in the office.	acility failed to have use of 1 of 1 heaters in the dance with NFPA 0.7.8. This ce is not in a rea but could affect Quality of Life e: evation with the at Operations on 18 p.m., there was in the Quality of ed on an interview or of Plant he time of e facility does not	K	0070	1. The employee was verbal counciled about the dangers space heater in the facility at the space heater was remove from the premises. 2. No residents, employees, or viswere adversely affect by this deficient practice.3. The maintenance department stabe watchful for any space he within the facility. If space heaters are found in the facility will be confiscated or the employee will be asked to rethe space heater immediately.4. Any issues involving space heaters will reported to the facility wide of committee on a quarterly bath Date of Completion 10/7/11	of a and red itors aff will eaters lity, see move	10/07/2011

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		01	COMPL 09/07/2	ETED
		155364	B. WIN			09/07/20	UII
	PROVIDER OR SUPPLIER			12101 L	ADDRESS, CITY, STATE, ZIP CODE		
BYRON	HEALTH CENTER			FORT V	VAYNE, IN46818		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0071 SS=F	(1) Any existing linincluding pneumatic systems, that oper is sealed by fire reprevent further used door assembly have of 1 hour. All new 9.5. (2) Any rubbish chapneumatic rubbish provided with autoprotection in accordance (3) Any trash chutecollection room usprotected in accordance (4) Existing flue-fefire resistive construse. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a assembly that in 9.5 requires constructed in accordance (3) Any trash chutecollection room usprotected in accordance (4) Existing flue-fefire resistive construse. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a assembly that in 9.5 requires constructed in accordance (3) Any trash chutecollection room usprotected in accordance (4) Existing flue-fefire resistive constructions. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a assembly that in 9.5 requires constructed in accordance (3) Any trash chutecollection room usprotected in accordance (4) Existing flue-fefire resistive constructions. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a assembly that in 9.5 requires constructions. 19.5 requires constructions are constructed in accordance (4) Existing flue-fefire resistive constructions. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a assembly that in 9.5 requires constructed in accordance (4) Existing flue-fefire resistive constructions. 19.5.4, 9.5 Based on obserinterview, the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided with a same construction of the femsure 1 of 1 laprovided	e discharges into a trash ed for no other purpose and dance with 8.4. d incinerators are sealed by ruction to prevent further 8.4, NFPA 82 vation and acility failed to aundry chutes was a fire rated door self closing. LSC impliance with LSC 2.1(b) requires fire self closing. This ce could affect all	K	0071	1. The laundry chute doors in soiled utility room on each of facility's three floors have be made operational and meet oby latching into the door frame.2. No residents or staff were found to have been adversely affected by this practice.3. Laundry chute do will be inspected by maintens staff as part of routine facility inspections. Any laundry chute doors found to be out of code will be repaired as soon as possible.4. Any facility issue	the en code f ors ance ute	10/07/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C7DX21 Facility ID:

lity ID: 000255

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364		LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/07/2011		
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA ROAD FORT WAYNE, IN46818				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			TAG	be reported to the facility wid committee on a quarterly basis.5. Date of completion 10/7/11	le QA	DATE	